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ABSTRACT

The P.E.P. Report 1969-1973 focuses on the various findings and activities of the Program Evaluation Project. This chapter of the report discusses the basic goal attainment scaling procedures. Goal attainment scaling is a methodology for developing personalized, multivariable, scaled descriptions which can be used for either therapy objective-setting or outcome measurement purposes. Originally developed as an assessment approach for individual clients in a community mental health milieu, goal attainment scaling has since been applied to goal setting for both individuals and organizations across the whole spectrum of human services. This chapter begins with an overview of the core of the goal attainment scaling methodology. The second section discusses the characteristics of utilizing the goal attainment followup guide for assessment purposes. The final section briefly outlines some of the major possibilities which have been implemented or suggested for varying the basic goal attainment scaling format while retaining the basic attainment scaling approach. (RC)

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CHAPTER ONE:

BASIC GOAL

ATTAINMENT SCALING PROCEDURES

U.S. DEPARTMENT OF HEALTH
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P.E.P. REPORT 1969-1973

TM005 495

A REPORT ON FOUR YEARS OF STAFF EFFORT AT, THE PROGRAM EVALUATION PROJECT.

CHAPTER ONE

Program Evaluation Project Report, 1969-1973

BASIC GOAL ATTAINMENT SCALING PROCEDURES

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General Introduction to the P.E.P. Report 1969-1973

The P.E.P. Report 1969-1973 focuses on the various findings and activities of the Program Evaluation Project. It is being published in pamphlet form, with one pamphlet for each chapter.

As of January, 1974, the Program Evaluation Project is funded by a three year collaborative grant with the Mental Health Services Division of the National Institute of Mental Health. The purpose of the grant is to emphasize the coordination and dissemination of information on a variety of program evaluation methodologies. Currently, it is expected that the title of the organization will be changed to the Program Evaluation Resource Center during 1974.

Further information on the Goal Attainment Scaling methodology and program evaluation is available in other written and recorded materials from the Program Evaluation Project office.

GOAL ATTAINMENT SCALING TIMELINE, 1969 to 1973

November, 1968	Publication of Kiresuk and Sherman article on Goal Attainment Scaling.
January, 1969	Dr. Cline at the Department of Psychiatry, University of Minnesota Medical School implements Goal Attainment Scaling with cooperative client/therapist follow-up guide construction.
February, 1970	First application of Goal Attainment Scaling at Hennepin County Mental Health Service in the comparison of four treatment modes.
March, 1970	Interjudging of Goal Attainment Follow-up Guides begins.
April, 1970	First Goal Attainment Scaling reliability study implemented by Program Evaluation Project. Adult Occupational Centre (for mentally retarded adults) begins implementation of Goal Attainment Scaling for evaluation, staff training and management.
May, 1970	Experimental follow-ups for Hennepin County Mental Health Service clients begins.
July, 1970	Regular follow-up of clients begins at Hennepin County General Hospital Mental Health Service.
October, 1970	Cooperative study with Dr. Moe on client vs therapist goals is begun.
November, 1970	Intensive content analysis program for Goal Attainment Follow-up Guide is begun. 1,000th Goal Attainment Follow-up produced by Hennepin County Mental Health Service staff.
December, 1970	100 Follow-up interviews completed for Program Evaluation Project.
February, 1971	Videotape of Intake at Mental Health Services is recorded.
March, 1971	Goal Attainment Scaling used to set administrative objectives for the Crisis Intervention Center.
April, 1971	200 follow-up interviews completed for the Program Evaluation Project.
July, 1971	Implementation of clinical Goal Attainment Scaling at the Crisis Intervention Center is begun, client and therapist jointly develop Goal Attainment Follow-up Guide as CIC starts operations.
August, 1971	2,000 Goal Attainment Follow-up Guides completed at the Hennepin County Mental Health Service. Dictionary & Index of Goal Attainment Scaling; Programmed Instruction in Goal Attainment Scaling; and Intake Procedures Manual are developed.
September, 1971	Program Evaluation Forum held.
December, 1971	500 follow-up interviews completed for Program Evaluation Project.
March, 1972	Feedback of outcome information to therapists at Hennepin County Mental Health Service is begun.
November, 1972	Publication of Garwick, Lampman article on Goal Attainment Scaling Content Analysis.
February, 1973	1,000 follow-up interviews completed for Program Evaluation Project.
October, 1973	Goal Attainment Scaling Workshop held.
December, 1973	End of first Program Evaluation Project four-year Grant sequence.

Background on Goal Attainment Scaling.

Goal Attainment Scaling is a methodology for developing personalized, multi-variable, scaled descriptions which can be used for either therapy objective-setting or outcome measurement purposes. Originally developed as an assessment approach for individual clients in a community mental health milieu, Goal Attainment Scaling has since been applied to goal setting for both individuals and organizations across the whole spectrum of human services.

The Goal Attainment Scaling concept was first proposed in a 1968 article by Drs. Kiresuk and Sherman (Kiresuk and Sherman, 1968). The methodology was then implemented by the staff of the Program Evaluation Project which was directed by Dr. Kiresuk and funded by the National Institute of Mental Health. The Program Evaluation Project staff has undertaken a variety of efforts to examine the feasibility, reliability and validity of the basic Goal Attainment Scaling approach. The investigation of new possibilites and variations of Goal Attainment Scaling has continued through the efforts of both the Program Evaluation Project staff and persons in other agencies.

This chapter begins with an overview of the core of the Goal Attainment Scaling methodology. The second section discusses the characteristics of utilizing the Goal Attainment Follow-up Guide for assessment purposes. The final section briefly outlines some of the major possibilities which have been implemented or suggested for varying the basic Goal Attainment Scaling format while retaining the basic Goal Attainment Scaling approach.

I. Basic Goal Attainment Scaling Procedures.

Designed for great flexibility, Goal Attainment Scaling is neither a specific set of instructions, nor a particular collection of pre-specified scales. Instead, it is a combination of an ideology, a type of record-keeping, and a series of techniques. The basic future-oriented, reality-testing approach on which Goal Attainment Scaling is based, duplicates in part the informal goal setting so often used by effective therapists and educators. In brief, Goal Attainment Scaling involves four steps:

a. collection of information about the person or organization for which goals will be scaled;

b. specification of the major areas where change would be feasible and helpful;

c. development of specific predictions for a series of outcome levels for each major area; and

d. scoring of the outcomes as they have been achieved by the time of a later follow-up interview.

(Even this fourth step is not essential to all uses of Goal Attainment Scaling. In some settings Goal Attainment Scaling has been used only to plan therapy and help the client set goals, so that the follow-up interview is not held and scoring is not carried out.) Roughly the same procedures are utilized when using Goal Attainment Scaling with organizations. (See chapter on Using Goal Attainment Scaling with Organizations in P.E.P. Report 1969-1973 for more specialized suggestions for goal setting for groups or organizations.) These four basic points will be discussed in greater detail below.

A. The Collection of Information.

From the client's statements, reports from the spouse, from other agencies, from relatives, from friends and from any other available information source, a pool of information is accumulated. In the original Program Evaluation Project staff research at the Hennepin County Mental Health Service Adult Outpatient unit one or two fifty-minute interviews plus examination of the client's information forms were the most common sources of knowledge for the clinician. In other settings, however, different schedules have been used for information collection. For an inpatient setting, information may be collected through records and contacts with the client over a period of several days.

B. Designation of Problem Areas.

The information collected about the client will often be a relatively amorphous mass of facts. This pool of information could be analyzed in a variety of ways, but Goal Attainment Scaling is based on separating the mass of facts into a series of "problem areas." These problems indicate areas where an undesirable set of behaviors should be minimized or where a favorable set of behaviors should be increased. The most significant, relevant problem areas should be selected for inclusion.

The Goal Attainment Scaling selection of problem areas may be carried out by a professional working alone, by the client, by both client and professional working together, by the family of the client and the professional, or through other possibilities. The procedures should be varied to meet the needs and capabilities of the agency. For example, if client participation is highly valued by the agency, then the client should be involved in the development of the problem areas.

The specified person(s) will select the problem areas most relevant to the client or organization involved. Each of these problem areas will be used to develop a continuum or scale of behaviors individually tailored to the client. In Figure I, a completed form for the recording of the problem areas appears. This form is called the Goal Attainment Follow-up Guide, and each vertical scale represents a scale of outcomes related to a problem area for a client.

In Goal Attainment Scaling as used in the Program Evaluation Project research, there is no upper limit on the number of scales to be prepared for each client. The Follow-up Guide in Figure I has only four completed scales, but others could have been added. If necessary, a second or even third form could also be used if more than five scales were desired. The highest number of scales known to have been constructed for one individual is ten. For organizations, from 10 to 60 scales have been utilized on the Goal Attainment Follow-up Guide. It is recommended that at least three or four problem areas be chosen, although a few clients may have only one or two scales.

Once the problem areas have been picked, each should be given a title. This title is designed to focus the attention on the problem areas of someone inspecting the follow-up guide. Each title should summarize a problem area in a few words and should be placed in the blanks across the top of the follow-up guide. The title may be abstract, theoretical or vague. This possibility is mentioned to emphasize that though the titles may be abstract or generalized, the remainder of the descriptions on the follow-up guide should be relatively specific and objective. In Figure I, the titles selected are Employment, Self-Concept, and Interpersonal Relationships.

When titles have been selected for the client's follow-up guide, a numerical weight can be added to each scale, beside the title. The weighting system utilized by the Program Evaluation Project staff to indicate the relative importance of the scales does not incorporate any pre-specified weights, but allows any one or two-digit number to be used. The higher the number used in the weight, the more significant the scale is, relative to the other scales. In Figure I, the weights selected are 10, 15, 5, 8, so that Scale 2 for the problem area "Self-Concept" with the weight of "10" is seen as the most important.

The title box can also be used to indicate any special sources of information for the scale. Special information sources might include "speak to spouse," "contact police department," "employer should help score this scale," and so on.

C. Predictions for Each Problem Area.

Goal Attainment Scaling operates within a time frame or time limit and all outcomes should be linked to this time frame. Thus, all Goal Attainment predictions should refer to specific outcomes at a specific target date in the future. In the original research at the Hennepin County

FIGURE I

GOAL ATTAINMENT FOLLOW-UP GUIDE

SCALE ATTAINMENT LEVELS	SCALE HEADINGS AND SCALE WEIGHTS				
	SCALE 1: Employment (Interest in work) self-report (w_1 = 10)	SCALE 2: Self-concept (physical appearance) patient interview (w_2 = 15)	Interpersonal Relation- SCALE 3: ships (in training program as judged by receptionist)(do not score (w_3 = 5) if he	SCALE 4: Interpersonal relationships (report of client's spouse) (w_4 = 8)	SCALE 5: (w_5 =)
a. most unfavorable treatment outcome thought likely	Client states he does not want to ever work or train for work.	Client 1) has buttons missing from clothes 2) unshaven (but says he is growing beard) 3) dirty fingernails 4) shoes unshined (if wearing shoes needs	does not go to training program. Never spontaneously talks to anyone. May answer if spoken to.	No friends and no close friends (i.e. "close" equals friends with which he can talk about serious, intimate topics and who he feels like his company).	
b. less than expected success with treatment	Client states that he may want to work "someday" (a year or more later) but not now, and no training.	shine) 5) socks don't match. 4 of the above 5 conditions.	Spontaneously talks to his own therapists or caseworkers, but no other clients.	One person who is a friend or acquaintance but not a close friend.	
c. expected level of treatment success	Client states that he might be interested in working within the next 12 months, but only if no training is required.	3 of the above 5 conditions.	Spontaneously talks to therapists, caseworkers and one other client.	Two or more persons who are friends, but not close friends.	
d. more than expected success with treatment	Client states that he might be interested in working within the next 12 months and training for no more than 30 work days.	2 of the above 5 conditions.	Spontaneously talks to therapists, caseworkers and 2 to 4 other clients.	One close friend, but no other friends.	
e. most unfavorable treatment outcome thought likely	Client states that he might be interested in working within the next 12 months. Will train for as many days as are necessary.	One of the above 5 conditions.	Spontaneously talks to therapists, caseworkers and 5 or more other clients.	One or more close friend, plus one or more other friends or acquaintances.	

Mental Health Service, clinicians constructed the follow-up guides and were allowed to set their own time frame for the follow-up guide. The most common option was the Program Evaluation Project-suggested schedule of a follow-up interview six months after the time the Goal Attainment Follow-up Guide was constructed. In the Hennepin County Crisis Intervention Center, where clinicians and clients worked together on most scales on the follow-up guides, the follow-up interview was usually scheduled for from one to three weeks after the construction of the follow-up guide. Currently, under the new evaluation system being developed for the Hennepin County Mental Health Service Outpatient Unit, follow-ups on therapy effectiveness are held three months after the follow-up is constructed. In a special study at the Hennepin County Mental Health Service Day Treatment Center, clients are constructing follow-up guides to be followed-up four months later. In short, the Goal Attainment scales should be constructed to be applicable to a future follow-up interview, and the length of time between follow-up guide construction and the follow-up interview should be adjusted to suit the needs of the individual agency. (See chapter on Follow-up Goal Attainment Scaling in P.E.P. Report 1969-1973.)

With the problem areas selected and the date of the follow-up interview established a series of predictions about the client's outcomes should be made. For each problem area, a number of variables are probably applicable as sources of measurement of outcome. The person (or group) constructing the Goal Attainment Follow-up Guide should select a variable for each problem area--a variable which is maximally useful for indicating treatment outcome and which can be efficiently, cheaply and reliably measured at the time of follow-up. (See Figure II.)

For each variable, a range of outcomes is possible at the time of follow-up. These outcomes should be presented in accord with the descriptions along the left edge of the Goal Attainment Follow-up Guide. (See Figure I.) These five descriptions range from the "most favorable outcome thought likely" to "more than expected level of outcome" to "expected level of outcome" to "less than expected level of outcome" to the "most unfavorable outcome thought likely." Judgment of the persons constructing a follow-up guide is used to assign a part of the range of a variable to each of these five levels. These five levels with behaviors assigned to them comprise an individually developed continuum or scale for each variable relevant to the client.

The key level for predictive purposes is the middle or "expected" level on each variable's five-point scale. The expected level presents the best and most realistic prediction possible of the outcome which will have been reached by the client by the date of the follow-up interview. The expectations ought to be pragmatic, so that the expected level of each scale reflects what outcome actually "could" be attained by the follow-up date, not necessarily what "should" be attained.

The estimate of the "expected" outcome ought to be independent of the client's current level of functioning. As a matter of fact, for some very regressed or chronic clients, the most accurate and realistic expectation might be that they would have deteriorated by the time of follow-up, so that their level of functioning when the follow-up guide is constructed might be better than the expected level of outcome. Of course, it is hoped that such cases are rare, but Goal Attainment Scaling is based on obtaining the best prediction possible so that the clinician is not penalized by being forced to set over-optimistic goals for very difficult clients.

FIGURE II

Hypothetical Field of Information Collected About the Client on the Follow-up Guide in Figure I

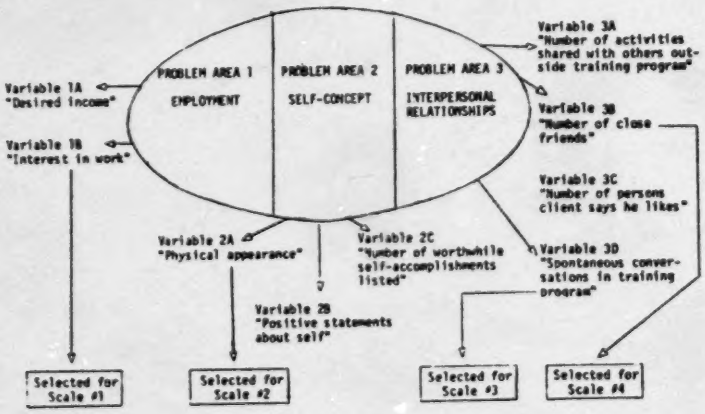
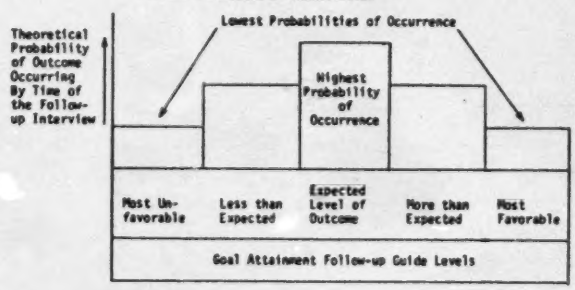

PROBLEM AREA 1
EMPLOYMENT
PROBLEM AREA 2
SELF-CONCEPT
PROBLEM AREA 3
INTERPERSONAL RELATIONSHIPS
Variable 1A "Desired income"
Variable 1B "Interest in work"
Variable 2A "Physical appearance"
Variable 2B "Positive statements about self"
Variable 2C "Number of worthwhile self-accomplishments listed"
Variable 3A "Number of activities shared with others outside training program"
Variable 3B "Number of close friends"
Variable 3C "Number of persons client says he likes"
Variable 3D "Spontaneous conversations in training program"
Selected for Scale #1
Selected for Scale #2
Selected for Scale #3
Selected for Scale #4

FIGURE III: Outcome Probabilities


Theoretical Probability of Outcome Occurring By Time of the Follow-up Interview
Lowest Probabilities of Occurrence
Highest Probability of Occurrence
Most Unfavorable
Less than Expected
Expected Level of Outcome
More than Expected
Most Favorable
Goal Attainment Follow-up Guide Levels

The expected level is usually developed first. The expected level of outcome should be the most likely outcome. The other outcome levels, which should be constructed after the expected level, should be less likely to occur.

The client's level of functioning at the time the follow-up guide is developed can be noted on a separate, standard form. (See Figure IV.) This form, called the "Client's Status at Intake" is intended to show the level on each scale on the Goal Attainment Follow-up Guide which is equivalent to the client's current functioning. When the initial level of functioning is known, the Goal Attainment Change score can be calculated after the level of functioning at the time the follow-up interview is scored. (See chapter on Goal Attainment Change Score in the P.E.P. Report 1969-1973.) Thus, at least two different kinds of effectiveness measures can be collected from the Goal Attainment Scaling system:

a. Whether or not the "expected" levels of outcome are reached.

b. Whether or not change occurred.

Experience with Goal Attainment Scaling suggests that an experienced follow-up guide constructor is able to complete the Goal Attainment Follow-up Guide in 15 to 30 minutes. If the follow-up guide is constructed jointly with the client, the process will require more time but there is greater opportunity for therapeutic interaction. At the Hennepin County General Hospital Mental Health Service, clinicians of all disciplines have constructed follow-up guides and have predicted outcomes fairly accurately. More than one third of the scales scored at follow-up were scored at the "expected" level, with another one third of the scales scored above that level. The types of problems and clients which are particularly difficult to predict are being studied by content analysis methods of the Project staff. (See the chapter on Clinicians Ability to Predict Outcomes in the P.E.P. Report 1969-1973.)

D. The Follow-up Interview.

At the Hennepin County General Hospital Mental Health Service study, the follow-up guides are prepared by one clinician, while a different clinician undertakes therapy. The follow-up interviews are carried out by still other persons, who are not part of either the Mental Health Service staff or the regular Program Evaluation Project staff. The bulk of the interviews have been carried out by master's degree Social Workers, but bachelor degree Social Workers, Registered Nurses, and undergraduates majoring in the social sciences have also participated as follow-up interviewers.

The Program Evaluation Project follow-up interview begins with a standardized series of questions about the client's satisfaction with the services received. (See chapter on Consumer Satisfaction in the P.E.P. Report 1969-1973.) Then the follow-up interviewer, without actually showing the follow-up guide to the client, will ask questions designed to lead to enough information to score the scales on the Goal Attainment Follow-up Guides. Other agencies using Goal Attainment Scaling have used different procedures and follow-up workers, with a variety of backgrounds, including therapy teams, psychiatric aides, and secretaries. The interviewer should score the most appropriate level of each scale on the follow-up guide, and the follow-up results are then collected by the Program Evaluation Project staff. These procedures are described in "Interviewer Procedures for Scoring the Goal Attainment Follow-up Guide" (Audette and Garwick, 1973).

FIGURE IV: For the Client in the Goal Attainment Follow-up Guide in Figure 1

Client Status at Intake

To facilitate the retention of the "level at intake" data, please complete this form for each Goal Attainment Follow-up Guide, using the following format.

Indicate the "level at the time of intake" with an asterisk in the appropriate cell for each scale completed. If the client's "level at intake" does not appear on a scale, put an asterisk in the cell marked "D.N.A." Any additional comments concerning the client's "level at intake" should be indicated on the reverse side of this form.

Scale 1	Scale 2	Scale 3	Scale 4	Scale 5
Much less than expected	Much less than expected	Much less than expected	Much less than expected	Much less than expected
Less than expected	Less than expected	Less than expected	Less than expected	Less than expected
Expected	Expected	Expected	Expected	Expected
More than expected	More than expected	More than expected	More than expected	More than expected
Much more than expected	Much more than expected	Much more than expected	Much more than expected	Much more than expected
D.N.A.	D.N.A.	D.N.A.	D.N.A.	D.N.A.

II. The Goal Attainment Score.

The most commonly used Goal Attainment score is based on the Kiresuk-Sherman formula, and is calculated based on the weights assigned to each scale and the level of outcome attained for each scale as is shown in Figure V. This formula is used to produce a single summary score for each Goal Attainment Follow-up Guide with a mean of 50 and a standard deviation of 10 plus a correction for the possibility of differing variances among the variables on the scales. Two manuals giving the Goal Attainment scores without calculation are available (Baxter, 1973 and Garwick and Brintnall, 1973).

Figure V

$$G.A.S. = 50 + \frac{10 \sum_{i=1}^{n} w_i x_i}{\sqrt{(1-\rho)\sum_{i=1}^{n} w_i^2 + \rho\left(\sum_{i=1}^{n} w_i\right)^2}}$$

where

x_i is the outcome score on the ith scale of the Goal Attainment Follow-up Guide,

w_i is the relative weight attached to the ith scale,

ρ is a weighted average intercorrelation of the scales, and

n is the number of scales on the Goal Attainment Follow-up Guide.

The basic Goal Attainment score converts the -2 to +2 values presented on the accompanying diagram to a score with a theoretical range from 15 to 85. A simplified "Scale-by-Scale" score can also be calculated by directly using these -2 to +2 outcome values.

FIGURE VI: The Values of the Level of a Single Goal Attainment Scale

Much less likely than thought	-2
Less than expected	-1
Expected	0
More than expected	+1
Much more than thought likely	+2

If a summary score with a -2 range is desired, the mean value can be determined, or a specialized formula, developed by Sherman and shown in Figure VII, can be used.

Figure VII:

$$G.A.S. = 50 + C \cdot \sum_{i=1}^{n} x_i$$

where C is a constant dependent only upon n:

TABLE OF COMPUTATIONAL CONSTANTS, $\rho = .3$

number of scales, n =	1	2	3	4	5
computational constant, C =	10.00	6.20	4.56	3.63	3.01

The scores based on the follow-up Goal Attainment Follow-up Guide can be used for feedback to either administrators, supervisors, clinicians or clients. (See the chapter on Feedback in P.E.P. Report, 1969-1973.) The basic Goal Attainment score reflects "whether or not the treatment accomplished what it was expected to accomplish." Thus, the Goal Attainment score is probably most valuable as a comparative measure, not an absolute measure. In the next section, a few new possibilities for producing or scoring the Goal Attainment Follow-up Guide are presented. Both procedures and type of score used should fit the agency.

III. Varieties of Goal Attainment Scaling.

The Goal Attainment Scaling methodology has been continually expanded ever since it was initiated. Part of this expansion is based on new and better knowledge of the way in which the Goal Attainment methodology operates. Another portion of this expansion is possible because of the development of new ideas and forms, such as, the Guide to Goals, One format or the idea of collaborative client-therapist follow-up guide construction.

Actually, the title of this section is somewhat misleading, for there are not clear-cut "varieties" or specific variations of Goal Attainment Scaling. Instead, there are several points within the Goal Attainment Scaling process where procedures can be varied and options can be added. Thus, there is a whole spectrum of applications and "variations" of Goal Attainment Scaling and the scores produced which can be used to meet the specific needs of agency clients, administrators and clinicians.

The four major steps within the Goal Attainment Scaling process were listed in Section I. Some recent possibilities for varying Goal Attainment Scaling within each of these steps will be discussed below. (See chapter on the Varieties of Goal Attainment Scaling in the P.E.P Report 1969-1973 for a more exhaustive list of possibilities.)

A. The Collection of Information.

Many clinicians express interest in changing the Goal Attainment Follow-up Guide as new information about the client is accumulated. Some persons have suggested that the follow-up guide be altered when new problems appear or when earlier problems disappear. It is recommended that such alterations of the Goal Attainment Follow-up Guide be undertaken only on a systematic basis, if at all. For example, if an agency staff decides to permit the alteration of the follow-up guide, they should only be altered within a given time after the original construction.

Short-term goals could, however, be represented on special forms. One possibility is shown in Figure VIII. With this form, the clinician may indicate short-term goal changes without destroying the predictive value of the original long-term Goal Attainment Follow-up Guide.

B. Designation of Problem Area.

Some agencies may wish to specify some types of problem areas which should be scaled for all clients. A criminal justice agency, for instance, may wish to have "Re-arrest" used as the basis for a scale for all of its parolees.

It may be useful for record-keeping purposes to outline a number of general types of problems. Each type could be given a number. When a problem area is selected, its number could be inserted at the top of a scale. These numbers are easily data-processed and enable an agency to get a rapid survey on the general types of problems being confronted by its clients.

C. Predictions for Each Problem Area.

The Guide to Goals, One format is a programmed version of Goal Attainment Scaling de-

FIGURE VIII:

Linking Long-term to Short-term Objectives

PROGRAM _____ DATE _____
SCORER _____ SHORT-TERM FOLLOW-UP NUMBER _____

CURRENT STATUS OF _____
(client's name)

A. LONG-TERM GOALS (TO BE SCORED _____ IN MONTHS)

Much less than expected	Much less than expected	Much less than expected	Much less than expected	Much less than expected
Less than expected	Less than expected	Less than expected	Less than expected	Less than expected
Expected	Expected	Expected	Expected	Expected
More than expected	More than expected	More than expected	More than expected	More than expected
Much more than expected	Much more than expected	Much more than expected	Much more than expected	Much more than expected
D.N.A.	D.N.A.	D.N.A.	D.N.A.	D.N.A.

B. SHORT-TERM OBJECTIVES (TO BE SCORED _____ PER WEEK)

1. Indicate the "current status or outcome" with a mark in the appropriate level for each scale. If the client's "current status" does not appear on a long-term scale, put a mark in the cell marked "D.N.A.".
2. Link at least one short-term objective to each long-term scale.
3. This form is derived from the Client Status at Intake form.

signed to lead the user through step-by-step development of a useful Goal Attainment Follow-up Guide (Garwick, 1972). This format has been applied to the Hennepin County Day Treatment Center, where clients appeared to be able to produce their own Goal Attainment Follow-up Guides with a mean of about five minutes of assistance from the clinical staff. A group of these Goal Attainment Follow-up Guides have been scored at follow-up and the results indicate a fairly high degree of reliability. If the clients can set their own predictions, the possibilities for cost-saving in evaluation with Goal Attainment Scaling are considerable.

D. The Follow-up Interview.

As commented earlier, one of the most striking developments in Goal Attainment Scaling utilization has been the popularity of clinical uses where the interactional aspects of the Goal Attainment Scaling process are emphasized more than evaluative uses. One survey suggested that of all the agencies considering Goal Attainment Scaling utilization, fifty-two per cent were interested in the non-evaluative uses where the follow-up and scoring are not stressed. (See chapter on Dissemination, Consultation, and Utilization in P.E.P. Report 1969-1973.)

The dynamics of using Goal Attainment Scaling in this way have not been extensively studied by the Program Evaluation Project staff. However, the interactional, reality-testing features of developing the Goal Attainment Follow-up Guide as part of therapy may be eventually as important as program evaluation with Goal Attainment Scaling.

Conclusion.

Further instruction on Goal Attainment Scaling may be obtained from various chapters of the P.E.P. Report 1969-1973 and from manuals such as the Programmed Instruction Manual (Garwick, 1973). The Newsletter Compendium may also be helpful (Brintnall, 1973). For more information, please write to Ms. Joan Brintnall, Program Evaluation Resource Center, 501 Park Avenue South, Minneapolis, Minnesota 55415.

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